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IN THE

Supreme Court of the United States

OCTOBER TERM, 1985

MICHAEL J. BOWERS,
Attorney General of Georgia,
Petitioner,
v.

MICHAEL HARDWICK, and JOHN and MARY DOE,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF OF *AMICI CURIAE* AMERICAN PSYCHOLOGICAL ASSOCIATION AND AMERICAN PUBLIC HEALTH ASSOCIATION IN SUPPORT OF RESPONDENTS

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BRIEF OF *AMICI CURIAE* AMERICAN PSYCHOLOGICAL ASSOCIATION AND AMERICAN PUBLIC HEALTH ASSOCIATION IN SUPPORT OF RESPONDENTS

INTEREST OF *AMICI CURIAE*

The American Psychological Association (hereafter "APA"), a nonprofit, scientific, and professional organization founded in 1892, is the major association of psychologists in the United States. APA has more than 60,000 members, including the vast majority of psychologists holding doctoral degrees from accredited universities in the United States. Among APA's major functions are promoting psychological research, improving research methods, and promulgating information regarding human psychological behavior. A substantial number of APA's members are concerned with the collection of data, development of research, and provision of therapy pertaining to human sexuality.

The American Public Health Association (hereafter "APHA") was founded in 1872 for the purposes of improving public health and the quality of health care. Together with its affiliated associations, APHA is the largest public health association in the world, with a combined multidisciplinary membership of approximately 50,000 physicians, nurses, immunologists, administrators, laboratory scientists, educators, biomedical researchers, and other health care professionals. By resolution, APHA supports the repeal of laws criminalizing private consensual sexual conduct, saving only those portions that protect children and other helpless persons. Because APHA has not adopted policy on certain mental health aspects of homosexuality, it takes no position with respect to Parts I-B and II-B of this brief. APHA is particularly able to address the absence of a public health rationale to support the statute at issue.

Petitioner and respondents have both consented to the filing of this brief. Their letters of consent have been filed with the Clerk of this Court.

INTRODUCTION AND SUMMARY OF ARGUMENT

Georgia's official code, O.C.G.A. § 16-6-2 (1984), criminalizes certain noncommercial, nonviolent sexual conduct between consenting adults, whether married or not, even if—as in this case—it takes place in the privacy of one's own bedroom. This case poses the question whether this statute, by intruding upon extremely intimate and private aspects of human life and personality, infringes fundamental human rights.

In answering this question, this Court should consider scientific, demographic, and clinical information concerning the intimate conduct made criminal by the statute. Despite some people's moral or theological objections to oral or anal sex, this conduct is extremely common among married and unmarried heterosexuals and homosexuals. Mental health professionals have found that the sexual conduct prohibited by Georgia is *not* harmful to health or social functioning, whether engaged in by persons of different sexes or the same sex. Clinical research also indicates that the freedom to engage in such conduct is important to the psychological health of individuals and of their most intimate and profound relationships. Like the decision whether to use contraceptives, the decision with whom and whether one will engage in these types of nonprocreative sexual conduct is among "the most private and sensitive" of decisions, concerning "the most intimate of human activities and relationships." *Carey v. Population Services Int'l*, 431 U.S. 678, 685 (1977). For these reasons, the statute violates the fundamental constitutional right of personal privacy. Point I.

Based on scientific and clinical data, *amici* also respectfully submit that the Georgia statute does *not* fur-

ther individual mental health or the public health. Indeed, in several ways, the statute actually disserves these goals. First, the Georgia statute does not contribute to combating the spread of acquired immunodeficiency syndrome (AIDS) or to achieving other public health goals. The statute adds nothing to the deterrent effect already created by the disease itself against conduct that *does* pose a risk of spreading AIDS. Moreover, for the overwhelming majority of people who violate the statute, deterring the proscribed conduct—even if the statute had this effect—would have virtually no impact on transmission of the disease. The threat of prosecution actually *harms* the public health effort by driving the disease underground where it is more difficult to study and contain and by impeding the flow of information about prevention from public health experts to the population at risk. Second, the statute contributes nothing to improving or safeguarding individual mental health. Because neither homosexuality nor the prohibited sexual conduct is pathological in and of itself, preventing the development of homosexuality and deterring the prohibited conduct cannot be defended as mental health goals, even if the statute had such effects (which it does not). The threat of criminal punishment actually has harmful psychological consequences for people who wish to engage in the proscribed conduct. Point II.

Amici respectfully urge this Court to affirm the Eleventh Circuit's decision in this case.

ARGUMENT

I. THE GEORGIA STATUTE IMPLICATES FUNDAMENTAL PRIVACY INTERESTS THAT ARE BASIC TO MARITAL RELATIONSHIPS AND TO NONMARITAL HETEROSEXUAL AND HOMOSEXUAL RELATIONSHIPS.

In *Carey v. Population Services Int'l*, this Court observed that it has not answered "the difficult question whether and to what extent" the Constitution prohibits

state statutes regulating "private consensual sexual behavior" among adults. 431 U.S. at 694, n. 17. In this case, the Court confronts a limited aspect of this issue: whether the constitutional right of personal privacy encompasses the right to engage in certain very common, nonpathological types of nonprocreative, consensual sexual conduct with another adult in the privacy of the home.[1] Respondent's claim to constitutional protection is particularly strong, because the statute intrudes upon two legally and psychologically distinct aspects of his privacy. First, the statute intrudes upon his independence in making "the most private and sensitive" decisions affecting "the most intimate of human activities and relationships." *Id.* at 685. Second, the statute invades his home, where an individual's expectation of territorial privacy is greatest. *E.g.*, *Payton v. New York*, 445 U.S. 573, 589 (1980).[2]

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[1] Not at issue, therefore, is the constitutional status of engaging in the conduct proscribed by the Georgia statute, or any other type of sexual conduct, in a location where one has a lesser expectation of privacy than the home, or for commercial purposes, or coercively, or with a minor.

[2] Researchers have observed both of these aspects of privacy. "Psychological privacy serves . . . to permit the individual to feel free to behave in a particular manner or to increase his range of options by removing certain classes of social constraints." Proshansky, Ittleson & Rivlin, *Freedom of Choice and Behavior in a Physical Setting*, in ENVIRONMENTAL PSYCHOLOGY: MAN AND HIS PHYSICAL SETTING 176 (Proshansky *et al.* eds. 1970). Privacy in the sense of controlling access to personal territory, such as the home, is very important to an individual's "selective control over access to the self or to one's group," Altman, *Privacy: A Conceptual Analysis*, in 6 MAN-ENVIRONMENT INTERACTIONS: EVALUATIONS AND APPLICATIONS, Pt. II, p. 6 (Carson *et al. eds.* 1974), as well as to a sense of well-being. *See, e.g.*, Vinsel, Brown, Altman & Foss, *Privacy Regulation, Territorial Displays, and Effectiveness of Individual Functioning*, 39 J. PERSONALITY & SOC. PSYCHOLOGY 1104 (1980).

A. The Georgia Statute Prohibits and Criminally Punishes Sexual Conduct that Is Common and Not Psychologically Harmful.

1. *The specific sexual conduct prohibited by the Georgia statute is common in marital relationships, and in nonmarital heterosexual and homosexual relationships.*

In 1948, Kinsey estimated that if the then extant criminal laws forbidding various sex acts were enforced, 95% of all white American males would be subject to prosecution.[3] Today, it is safe to conclude that a vast majority of all adult Americans—men and women, married and unmarried, heterosexual and homosexual—have engaged in the intimate conduct made felonious by Georgia.

Statistical studies show that the sexual conduct criminalized by Georgia is commonplace among predominantly heterosexual people. Kinsey's data show that, as of the early 1950s, 54% of exclusively or predominantly heterosexual men and 49% of exclusively or predominantly heterosexual women engaged frequently in oral or anal sex.[4] Kinsey also reported that 60% of married, college-educated people engaged in oral sex on a fairly regular basis.[5] A major study of couples in the United States published in 1983 found that 90% of the married and unmarried heterosexual couples studied had engaged in fellatio and that 93% of these couples had engaged in cunnilingus.[6] Other recent surveys similarly report that

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[3] A. KINSEY, W. POMEROY & C. MARTIN, SEXUAL BEHAVIOR IN THE HUMAN MALE 390-93 (1948) [hereafter KINSEY 1948].

[4] A. KINSEY, W. POMEROY, C. MARTIN & P. GEBHARD, SEXUAL BEHAVIOR IN THE HUMAN FEMALE (1953) [hereafter KINSEY 1953]; KINSEY 1948, *supra* note 3, at 368-70.

[5] *Id.*

[6] P. BLUMSTEIN AND P. SCHWARTZ, AMERICAN COUPLES 236 (1983) [hereafter BLUMSTEIN & SCHWARTZ]. This national study of 12,000 people compared married couples, unmarried heterosexual couples, gay male couples, and lesbian couples currently living together. The researchers also reported that 72% of married and

80-90% of all married couples engage in oral sex.[7]

Studies also demonstrate that oral-genital sex is a basic component of heterosexual relations in the United States among substantial percentages of married and unmarried adults of every age. One recent study found that approximately 80% of single men and women aged 25-34 have engaged in oral-genital sex.[8] Another recent major study reported that, after reaching the age of 50, 43% of women and 49% of men had engaged in fellatio, and 49% of women and 56% of men had engaged in cunnilingus.[9]

Fewer data exist on the incidence of anal intercourse between women and men. One researcher found that 25% of married couples under 35 years old had engaged in anal intercourse in the year preceding the study.[10] Another study found that 16% of heterosexual men and women reported having had their anus stimulated during sex after reaching the age of 50.[11]

Reliable data on the incidence of homosexual orientation are difficult to obtain due to the criminal penalties and social stigma attached to homosexual behavior and the consequent difficulty of obtaining representative samples of people to study. A recent report conservatively

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unmarried heterosexual couples engaged in fellatio, and 74% engaged in cunnilingus, every time they had sex, frequently, or sometimes. *Id.*

[7] *E.g.*, C. TAVRIS & S. SADD, THE REDBOOK REPORT ON FEMALE SEXUALITY (1977) [hereafter REDBOOK REPORT] (85% of married couples engaged in cunnilingus, and over 83% engaged in fellatio, often or occasionally); M. HUNT, SEXUAL BEHAVIOR IN THE SEVENTIES 198-99 (1974) (90% of married couples under 25 years old engaged in oral sex).

[8] M. HUNT, *supra* note 7.

[9] E. BRECHER, LOVE, SEX, AND AGING: A CONSUMER'S UNION REPORT 358-59 (1984) [hereafter LOVE, SEX, AND AGING].

[10] M. HUNT, *supra* note 7, at 204. 6% of the sample reported engaging in anal intercourse "sometimes" or "often."

[11] LOVE, SEX, AND AGING, *supra* note 9, at 363.

estimates that more than five million people in the United States are exclusively homosexual.[12] Another commentator suggests that the population of persons with a homosexual orientation is 25 million men and women.[13] The practices criminalized by the Georgia statute are primary aspects of sexual expression available to homosexual people.[14]

2. ***The sexual conduct criminalized by the statute is not, by itself, pathological or harmful to the individual or individual functioning, whether engaged in with a member of the opposite or the same sex.***

The sexual conduct prohibited by O.C.G.A. § 16-6-2 is not pathological; that is, it is not detrimental to an individual's happiness or functioning. The American Psychiatric Association's *Diagnostic and Statistical Manual*

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[12] R. FRANCOEUR, BECOMING A SEXUAL PERSON (1982). As used herein, "homosexual" refers to people who have a definite sexual orientation and emotional attraction to and engage in sexual conduct with persons of the same sex. Paul & Weinrich, *Whom and What We Study*, in HOMOSEXUALITY: SOCIAL, PSYCHOLOGICAL, AND BIOLOGICAL ISSUES 23 (Paul *et al.* eds. 1982) [hereafter HOMOSEXUALITY] (Final report of the Task Force on Sexual Orientation of APA's Division 9 (The Society for the Psychological Study of Social Issues), a four-year national research and education project producing a comprehensive body of empirical evidence contributed by 22 authors and subjected to several independent reviews).

[13] Paul, *Social Issues and Homosexual Behavior: A Taxonomy of Categories and Themes in Anti-Gay Argument*, in HOMOSEXUALITY, *supra* note 12, at 25-26 (1982).

[14] One recent study reports that 89% of male couples and 77% of lesbian couples regularly engage in oral sex. Only 1% and 4% respectively reported never engaging in oral sex with their partners. BLUMSTEIN & SCHWARTZ, *supra* note 6, at 236. 17% of male couples and 12% of lesbian couples reported engaging in oral sex every time they had sexual relations. *Id.* 70% of male couples reported regularly engaging in anal intercourse. *Id.* at 243. Another major study, limited to male couples, found that about 95% of the sample reported engaging in fellatio and about 71% reported engaging in anal intercourse at some time during the preceding year. D. MCWHIRTER & A. MATTISON, THE MALE COUPLE: HOW RELATIONSHIPS DEVELOP 277 (1984) [hereafter MCWHIRTER & MATTISON].

(Third Edition), used as an authoritative description of diagnostic categories of mental disorders by health care practitioners and the insurance industry, does not include in its catalogue of pathological sexual syndromes either oral or anal sex between persons of different sexes or the same sex.[15] Mental health clinicians have long observed that diverse expressions of sexual feelings between consenting adults are not symptoms of mental disorder, but rather of mental health. A recent study of public attitudes toward oral sex indicated that a substantial majority of Americans consider oral-genital contact to be "part of normal sex."[16] No significant data show that engaging in a variety of sexual expressions, including oral and anal sex, results in mental or physical dysfunction.[17] Indeed, *repression* of desires for such expression can lead to dysfunction and pathology.[18]

3. *Homosexuality is not a disorder.*

The vast majority of mental health professionals no longer consider homosexuality to be a disorder.[19] In

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[15] AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL 261-83 (3d ed. 1980) [hereafter DSM-III].

[16] Callan & Planco, *Attitudes Towards Oral-Genital Sexuality*, 42 CONN. MED. 500, 502 (1978) [hereafter Callan & Planco]. 91% of persons under 35, and 78% of all persons, said they consider oral sex to be normal.

[17] Mental problems *associated* with such sexual expression, whether engaged in by heterosexual or homosexual people, are usually the product of internalized social condemnation of those who practice it. Thus, the pathologies sometimes associated with variant sexual conduct can be viewed as social rather than personal pathologies. *See* Gonsiorek, *Social Psychological Concepts in the Understanding of Homosexuality*, in HOMOSEXUALITY, *supra* note 12, 115-19 (1982).

[18] W. MASTERS & V. JOHNSON, HUMAN SEXUAL INADEQUACY (1970); *see* Coleman, *Developmental Stages of the Coming-Out Process*, in HOMOSEXUALITY, *supra* note 12, 150-51 (1982); P. FISHER, THE GAY MYSTIQUE, THE MYTH AND REALITY OF MALE HOMOSEXUALITY 249 (1972). *See* pp. 28-30, *infra*.

[19] A mental disorder is "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that

1973, the American Psychiatric Association removed homosexuality from its list of mental disorders, declaring that "homosexuality *per se* implies no impairment in judgment, stability, reliability or general social or vocational capabilities," and concluded that "[i]n the reasoned judgment of most American psychiatrists today, homosexuality *per se* does not constitute any form of mental disease." [20] In 1975, *amici* APA and APHA passed resolutions supporting the Psychiatric Association's action and urging all mental health professionals to help dispel the stigma of mental illness that long had been associated with homosexual orientation.[21]

The declassification of homosexuality as a mental disease was the result of a long reevaluation of the "illness model" of homosexuality and was based on extensive scientific findings by a large number of independent researchers.[22] The first major challenge to the illness model

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is typically associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability)." DSM-III, *supra* note 15, at 6.

[20] Resolution of the American Psychiatric Association, December 15, 1973. In part, DSM-III explains that "[a] significant proportion of homosexuals . . . show no significant signs of manifest psychopathology . . . and are able to function socially and occupationally with no impairment. If one uses the criteria of *distress* or *disability*, homosexuality *per se* is not a mental disorder." DSM-III, *supra* note 15, at 380 (emphasis in original). DSM-III lists "ego-dystonic homosexuality" as a mental disorder consisting of a desire of a homosexually behaving person to acquire or increase heterosexual arousal. *Id.* at 281. This is not an inevitable result of homosexual orientation, but is a condition suffered by only a small percentage of homosexuals, generally as a result of internalized social condemnation. *See* note 17, *supra*.

[21] Resolution of the Council of Representatives of the American Psychological Association (1975); Resolution No. 7514 of the American Public Health Association (1975).

[22] According to *amicus* APA's Task Force on Sexual Orientation, the research that had supported the "illness model" of homosexuality was "influenced by poorly founded stereotypes and social prejudice." Weinrich, *Task Force Findings: Overview and Prospect*, in HOMOSEXUALITY, *supra* note 12, at 377 (1982).

came in 1957 when Dr. Evelyn Hooker determined that homosexual and heterosexual men could not be distinguished from each other on the basis of standard psychological tests, and that a similar majority of the two groups appeared to be free of psychopathology.[23] Of course, some homosexuals, like some heterosexuals, are psychologically disturbed. But extensive psychological research conducted over almost three decades has conclusively established that homosexuality is not related to psychological adjustment or maladjustment.[24] One commentator who has reviewed the extensive psychological literature on the subject concluded that "theories contending that the existence of differences between homosexuals and heterosexuals implies maladjustment are irresponsible, uninformed, or both." [25]

Moreover, cross-cultural studies reveal that homosexuality is widely practiced in a variety of societies around the world.[26] Anthropological and historical evidence re-

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[23] Hooker, *The Adjustment of the Male Overt Homosexual*, 21 J. PROJECTIVE TECHNIQUES 17 (1957). Subsequent studies have replicated these findings with female samples. *See, e.g.*, M. FREEDMAN, HOMOSEXUALITY AND PSYCHOLOGICAL FUNCTIONING (1971).

[24] *See* Gonsiorek, *Results of Psychological Testing on Homosexual Populations*, 25 AM. BEHAVIORAL SCI. 385, 394 (1982) [hereafter *Psychological Testing*]; Reiss, *Psychological Tests in Homosexuality*, in HOMOSEXUAL BEHAVIOR: A MODERN REAPPRAISAL 296-311 (Marmor ed. 1980) [hereafter Reiss]; Hart, Roback, Tittler, Weitz, Walston & McKee, *Psychological Adjustment of Nonpatient Homosexuals: Critical Review of the Research Literature*, 39 J. CLINICAL PSYCHIATRY 604 (1978).

[25] *Psychological Testing*, *supra* note 24, at 394; *see* Reiss, *supra* n. 24, at 308. Although some researchers have postulated that homosexuality may result from a different hormonal constitution, a series of studies has failed to establish that homosexual people are characterized by abnormal hormone levels or other abnormal physiological characteristics. *See* Ricketts, *Biological Research on Homosexuality: Ansell's Cow or Occam's Razor?* 9 J. HOMOSEXUALITY 65 (1984); Meyer-Bahlberg, *Homosexual Orientation in Women and Men: A Hormonal Basis*, in THE PSYCHOBIOLOGY OF SEX DIFFERENCES AND SEX ROLES 105-130 (Parsons ed. 1980).

[26] Carrier, *Homosexual Behavior in Cross-Cultural Perspective*, in HOMOSEXUAL BEHAVIOR: A MODERN REAPPRAISAL 100-22 (Marmor

veals that homosexuality, and the proscribed forms of nonprocreative sexual expression, have been common in western societies since before the Christian era.[27] Homosexuality has been ubiquitous, whether a particular culture admired, ignored, or vilified it.[28] There is no evidence that the incidence of homosexuality increases or decreases significantly as a result of any particular constellation of cultural conditions.[29]

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ed. 1980); C. FORD & F. BEACH, PATTERNS OF SEXUAL BEHAVIOR 143 (1951).

[27] Although the amount and modes of sexual activity at any time in history are difficult to ascertain, the victory of Christian doctrine may have led to the repression of the freer sexual attitudes of the Greeks and Romans. M. GOODICH, THE UNMENTIONABLE VICE: HOMOSEXUALTY IN THE LATER MEDIEVAL PERIOD x (1979). In the first thousand years of Christianity there was a considerable range of tolerance for homosexual conduct. J. BOSWELL, CHRISTIANITY, TOLERANCE & HOMOSEXUALITY, chs. 1 & 2 (1980). In the Thirteenth Century, however, St. Thomas Aquinas in effect defined homosexual conduct as more "unnatural" than other "unnatural" sex, such as masturbation, nonprocreative or nonmarital heterosexual conduct, and procreative heterosexual intercourse in other than the approved position. Gilbert, *Conceptions of Homosexuality and Sodomy in Western History*, 6 J. HOMOSEXUALITY 57, 62 (1981). Aquinas' hierarchy was first embodied in canon law, V. BULLOUGH, SEXUAL VARIANCE IN SOCIETY AND HISTORY 380-81 (1976), and these ecclesiastical proscriptions later became part of the criminal codes or common law of England and other European countries. P. CONRAD & J. SCHNEIDER, DEVIANCE AND MEDICALIZATION: FROM BADNESS TO SICKNESS 172-79 (1980). What had been a sin became a crime. With the Eighteenth Century Age of Enlightenment, "science" constructed a concept of health based largely on earlier concepts of morality. Conduct regarded as morally excessive—such as oral and anal sex, masturbation, and other nonprocreative sexual activities—was believed to make extraordinary demands on the body and lead to disease. Homosexuality was viewed as pathological. *Id.* at 179-85. This transition from sin to crime to illness has now been reversed. The criminal laws of Georgia, however, are still based on the disproven, religiously based concept of "unnatural acts."

[28] *See* V. BULLOUGH, *supra* note 27; J. BOSWELL, *supra* note 27; Karlen, *Homosexuality in History*, in HOMOSEXUAL BEHAVIOR: A MODERN REAPPRAISAL 75-99 (Marmor ed. 1980).

[29] *Id.* Recent research has not indicated an increase in the incidence of homosexuality since the Kinsey studies were conducted

B. The Freedom to Express Intimacy through the Sexual Conduct Prohibited by the Georgia Statute Is Important to the Psychological Health of Individuals and Intimate Human Relationships.

This Court has recognized that the Constitution "afford[s] the formation and preservation of certain kinds of highly personal relationships a substantial measure of sanctuary from unjustified interference by the State." *Roberts v. United States Jaycees*, 104 S. Ct. 3244, 3250 (1984). This right of private association is based on the fact that "individuals draw much of their emotional enrichment from close ties with others. Protecting these relationships from unwarranted state interference therefore safeguards the ability independently to define one's identity that is central to any concept of liberty." *Id.*

One such protected relationship is marriage, *see, e.g.*, *Zablocki v. Redhail*, 434 U.S. 374 (1978), which is among the family relationships that, "by their very nature, involve deep attachments and commitments to the necessarily few other individuals with whom one shares not only a special community of thoughts, experiences, and beliefs but also distinctively personal aspects of one's life," *Roberts v. United States Jaycees*, 104 S. Ct. at 3250. Because physical and sexual contact is basic to marital relationships, the Constitution protects this sexual intimacy from unreasonable state intrusion. *See, e.g.*, *Griswold v. Connecticut*, 381 U.S. 479 (1965).

The Constitution protects the privacy and associational rights of the "*individual*, married or single," *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) (emphasis in original), and constitutional protection of marital in-

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over 30 years ago, despite greater tolerance for and awareness of homosexual lifestyles. *See* P. GEBHARD & A. JOHNSON, THE KINSEY DATA: MARGINAL TABULATION OF THE 1938-1963 INTERVIEWS CONDUCTED BY THE INSTITUTE FOR SEX RESEARCH (1979); Gebhard, *Incidence of Overt Homosexuality in the U.S. and Western Europe*, NIMH Task Force on Homosexuality, DHEW Pub. No. (HSM) 9116 (Livingood ed. 1972).

timacy is based upon the recognition that a marriage is an "association of two individuals each with a separate intellectual and emotional makeup." *Id.* Thus, constitutional protection of sexual intimacy is not limited to the marital relationship, *see Carey v. Population Services Int'l*, 431 U.S. at 686-87, but necessarily extends to other important, emotionally enriching associations in which sexuality plays a similarly intimate and central role.

1. *Marriage and the relationships of unmarried heterosexual couples and homosexual couples are psychologically important.*

The American family, and the American household, have changed more in the last 30 years than in the previous 250.[30] People are marrying less, marrying later, and divorcing more.[31] Researchers also note a marked increase in unmarried heterosexual cohabitation; between 1970 and 1981, the total of such households tripled. In 1981, there were approximately 1.8 million unmarried couples of the opposite sex living together in the United States.[32] Moreover, a high percentage of lesbians and gay men live with a partner. In the late 1960s, the Kinsey Institute found that 71% of its sample of gay men aged 36-45 were living with a partner.[33] Another study, done in the 1970s, found that 82% of the lesbians in the sample were currently living with someone.[34] A recent major study of married, cohabiting heterosexual, and gay couples in the United States concludes that

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[30] BLUMSTEIN & SCHWARTZ, *supra* note 6, at 25-45.

[31] *Id.* at 31, 33-34.

[32] *Id.* at 36; *see* Spanier, *Married and Unmarried Cohabitation in the United States: 1980*, 45 J. MARRIAGE & FAMILY 277 (1983).

[33] M. WEINBERG & C. WILLIAMS, MALE HOMOSEXUALS: THEIR PROBLEMS AND ADAPTATIONS (1974) [hereafter WEINBERG & WILLIAMS].

[34] A. BELL & M. WEINBERG, HOMOSEXUALITIES: A STUDY OF DIVERSITY AMONG MEN AND WOMEN (1978) [hereafter BELL & WEINBERG].

" '[c]ouplehood,' either as a reality or an aspiration, is as strong among gay people as it is among heterosexuals." [35]

Recent social science research indicates that these nontraditional types of couples share principal elements of the marital relationship. Like married couples, unmarried heterosexual couples and homosexual couples form deep emotional "attachments and commitments," *Roberts v. United States Jaycees*, 104 S. Ct. at 3250, to each other.[36] All couples—whether married, unmarried heterosexual, gay male, or lesbian—confront a common set of issues, and confront them in similar ways. Principal concerns for all types of couples include equity, loyalty, stability, intimacy, and love.[37] The nontraditional couples also often make substantial commitments to each other and in many cases stay together for decades.[38]

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[35] BLUMSTEIN & SCHWARTZ, *supra* note 6, at 45; *see* Peplau, Padesky & Hamilton, *Satisfaction in Lesbian Relationships*, 8 J. HOMOSEXUALITY 23 (1982); Peplau & Cochran, *Value Orientations in the Intimate Relationships of Gay Men*, 6 J. HOMOSEXUALITY 1 (1981). Researchers found that gay male couples "form family units just as stable, dependable, and contributing to the commonwealth as any traditional nuclear family. Many participate actively in civic, church, neighborhood, and political life, most often alongside their nongay neighbors and friends. . . ." MCWHIRTER & MATTISON, *supra* note 14, at 286.

[36] *See* BLUMSTEIN & SCHWARTZ, *supra* note 6, at 170-174, 332-545; BELL & WEINBERG, *supra* note 34; Peplau, *Research on Homosexual Couples: An Overview*, 8 J. HOMOSEXUALITY 3, 5 (1982) [hereafter Peplau]; Peplau, Padesky & Hamilton, *supra* note 35, at 27-28, 34-35; Larson, *Gay Male Relationships*, in HOMOSEXUALTY, *supra* note 12, at 223-25 (1982); Peplau & Amaro, *Understanding Lesbian Relationships*, in HOMOSEXUALITY, *supra* note 12, at 233-47 (1982); Peplau & Cochran, *supra* note 35.

[37] *See generally* MCWHIRTER & MATTISON, *supra* note 14; BLUMSTEIN & SCHWARTZ, *supra* note 6; Peplau & Amaro, *supra* note 36, at 237-39; Peplau, *supra* note 36, at 4-5; Cardell, Finn & Marecek, *Sex-Role Identity, Sex Role Behavior, and Satisfaction in Heterosexual, Lesbian and Gay Male Couples*, 5 PSYCHOLOGY OF WOMEN Q. 488 (1981).

[38] *See, e.g.*, MCWHIRTER & MATTISON, *supra* note 14, at 285-86; Peplau, *supra* note 36, at 4.

Sexuality is an important element in the lives and relationships of all four types of couples. For all four kinds of couples, sex functions as a complex bond between the partners, and for all "a good sex life is central to a good overall relationship." [39] Married or not, heterosexual or homosexual, "[h]aving sex is an act that is rarely devoid of larger meaning for a couple. It always says something about partners' feelings about each other, what kind of values they share, and the purpose of their relationship." [40] As discussed, oral sex and other sexual acts other than vaginal intercourse are common for all four types of couples. In short, there are great similarities among homosexual and heterosexual couples—in emotional makeup, significance of the relationship to the individual, and in the role sexuality plays in the relationship.

2. *The sexual conduct prohibited by the Georgia statute is important to the psychological health of many individuals and their basic human relationships.*

As noted, oral and anal intercourse are not harmful or pathological. In fact, they substantially benefit many people, both heterosexuals and homosexuals, and many relationships. Married men who engage in oral sex with their wives are happier with their sex lives and more satisfied with their relationships in general than those who do not. The same is true for men in unmarried heterosexual couples. Lesbian and gay male couples who engage in oral sex are also happier than those who do not.[41] Homosexual people also benefit by engaging in behavior that affirms their self-concept, provides emotional satisfaction, and

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[39] BLUMSTEIN & SCHWARTZ, *supra* note 6, at 201, 205-06; *see* MCWHIRTER & MATTISON, *supra* note 14, at 262.

[40] BLUMSTEIN & SCHWARTZ, *supra* note 6, at 193.

[41] *Id.* at 231 (married and unmarried heterosexual couples); *id.* at 239-240 (lesbians and gay male couples). Only for heterosexual women does engaging in oral sex not correlate—positively or negatively—with happiness in the relationship. *Id.* at 233-37.

allows the formation of long-term bonds.[42] Indeed, a majority of Americans sampled in a 1978 study agreed that "oral-genital sex leads to better and happier relationships." [43]

These findings are not surprising. The theme of sexual flexibility appears throughout the scientific literature on sex therapy. Virtually every expert in the field has recognized the importance of sexual contact through behaviors other than vaginal intercourse. Underlying Masters and Johnson's once-innovative sex therapy was the theme of abstinence from intercourse and use of "sensate focus" exercises to expand a couple's sensitivity and sexual repertoire.[44] Oral and anal sexuality also are a significant source of sexual pleasure for a large majority of participants of both sexes and all ages.[45]

The many practitioners in sex therapy also work from the assumptions that reliance on vaginal intercourse as a sole sexual activity is not healthy, and that couples need to expand their behavior options. Oral-genital contact, in particular, has been recommended for inorgasmic women, because only a minority of women respond orgasmically

[42] McWhirter & Mattison, *supra* note 14, at 262; Bell & Weinberg, *supra* note 34, at 217-18; Peplau, *What Homosexuals Want in Relationships*, 15 Psychology Today 28 (1981).

[43] Callan and Planco, *supra* note 16, at 502.

[44] W. Masters & V. Johnson, Human Sexual Inadequacy (1970); W. Masters & V. Johnson, Human Sexual Response (1966).

[45] *See* Love, Sex, And Aging, *supra* note 9, at 358-59, 363 (98% of men and 75% of women over 50 who have experienced fellatio enjoyed it; 82% of women and 95% of men over 50 who have experienced cunnilingus enjoyed it; 86% of men and 67% of women who have been anally stimulated during sex since reaching the age of 50 enjoyed it); Redbook Report, *supra* note 7 (82% of wives reported they enjoyed cunnilingus; 65% of wives reported they enjoyed fellatio); S. Hite, The Hite Report: A Nationwide Study On Female Sexuality 76 (1976) (30% of female sample said they enjoyed anal intercourse).

to intercourse without other stimulation.[46] Human sexuality texts consistently support the concept of sexual conduct other than conventional intercourse to enhance sexual functioning and health.[47] Persons experiencing sexual dysfunction benefit from therapy that requires the use of non-coital sexual techniques.[48] These techniques improve mental health by increasing feelings of sexual competence, intimacy, and self-esteem. Even among married couples seeking fertility counseling and wanting to reproduce, behaviors other than vaginal intercourse are commonly recommended as a way to ease the pressure and perhaps increase sexual arousal and frequency of orgasm, which is known to increase the probability of conception in women.[49]

The Georgia statute invades fundamental privacy interests in yet another way: it deprives heterosexual couples who do not desire to produce a pregnancy of the opportunity to engage in non-coital sexual behavior in addition to, or instead of, using contraception. *See Carey v. Population Services Int'l*, 431 U.S. 678; *Eisenstadt v. Baird*, 405 U.S. 438; *Griswold v. Connecticut*, 381 U.S. 479.

For these reasons, the effect of the Georgia statute is to deprive all couples of options that may—and in many cases do—enhance the quality of their lives and their most intimate relationships.

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[46] L. BARBACH, FOR YOURSELF, THE FULFILLMENT OF FEMALE SEXUALITY (1975) [hereafter L. BARBACH].

[47] *See, e.g.*, R. KOLODNY, W. MASTERS & V. JOHNSON, TEXTBOOK ON SEXUAL MEDICINE (1979) [hereafter R. KOLODNY, *et al.*]; MCCARY, MCCARY'S HUMAN SEXUALITY (1978); H. KATCHEDOURIAN & D. LUNDE, FUNDAMENTALS OF HUMAN SEXUALITY (1975).

[48] L. BARBACH, *supra* note 46; *see* W. MASTERS & V. JOHNSON, HOMOSEXUALITY IN PERSPECTIVE 208-09 (1979) (functional failure rates for sexually experienced men and women are four times higher for coition than for fellatio or cunnilingus).

[49] *E.g.*, J. GAGNON, HUMAN SEXUALITIES 131, 193-214 (1977).

3. For many disabled heterosexual people the prohibited conduct may be among the only available kinds of intimate sexual contact.

Heterosexual people who are unable to engage in vaginal intercourse because of physical disability or handicap also benefit from the intimate contact that is provided by non-coital sexual behavior. Such individuals are encouraged by their therapists and rehabilitation specialists to use such behaviors as oral and anal stimulation to ensure the continuation of a pleasurable physical relationship with their loved ones. Such contact, in fact, has been shown to be a crucial determinant of survival itself for certain patients who may not be able to have intercourse and would otherwise terminate physical contact relationships.[50] Moreover, physically disabled men and women who achieve a level of sexual functioning that is personally satisfying will usually develop the self-confidence and assertiveness necessary to form meaningful relationships, to develop work skills, and to be otherwise productive.[51] The range of disabilities that may interfere with conventional vaginal intercourse is substantial.[52] The Georgia statute has

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[50] J. LYNCH, THE BROKEN HEART: THE MEDICAL CONSEQUENCES OF LONELINESS (1977).

[51] Cole, *Sex and the Paraplegic*, MED. WORLD NEWS 35 (January 17, 1972). The development of an adequate self-image may be a central element in total habilitation and rehabilitation. Weiss & Diamond, *Sexual Adjustment, Identification, and Attitudes of Patients with Myelopathy*, 47 ARCHIVES OF PHYSICAL MED. & REHABILIATION 245 (1966); Lindner, *Perceptual Sensitization to Sexual Phenomena in the Chronic Physically Handicapped*, 9 J. CLINICAL PSYCHOLOGY 67 (1953).

[52] For example, many people with significant medical problems or physical disabilities are unable to participate in intercourse due to organic erectile dysfunction, pain, or surgical trauma to the genitals. R. KOLODNY, *et al.*, supra note 47. Some women may have pain with intercourse as a result of arthritis or dryness due to aging; others may have had cancer surgery that removed or greately constricted the vagina. Forms of sexual expression other than vaginal intercourse may, however, be pleasurable and satisfying to them. For some men, oral stimulation might be used to produce an erec-

the effect of making criminal the principal sexual activities available to such disabled people.

The conduct prohibited by the statute therefore forms an important part of extremely private and sensitive aspects of intimate human relationships in a majority of the households in this country. For homosexual couples, and for some disabled heterosexual couples, the prohibited forms of conduct are the primary means of sexual expression. For these reasons, the Eleventh Circuit correctly decided that the Georgia statute infringes respondent's fundamental constitutional rights, and that the interests advanced by the State as justifying this intrusion must be subjected to heightened judicial scrutiny.

II. THE GEORGIA STATUTE DISSERVES THE LEGITIMATE OBJECTIVES OF IMPROVING THE PUBLIC HEALTH AND INDIVIDUAL MENTAL HEALTH.

The question whether and to what extent the statute serves any legitimate state objectives is not properly before this Court. These issues remain to be determined on remand. Nevertheless, one *amicus* brief supporting the State asserts erroneously that O.C.G.A. § 16-6-2 is justified as a health measure. Brief of David Robinson, Jr. *Amici* APHA and APA submit that this is simply not true.[53]

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tion or to facilitate orgasm. LOVE, SEX, AND AGING, *supra* note 9, at 359. Moreover, for some men with spinal cord injuries, stimulation of the penis during intercourse can result in automatic dysreflexia, which can be a life-threatening increase in blood pressure. It is absolutely necessary for these men to find other ways, such as with oral stimulation, to please their wives or partners. Lenz, *Becoming Active Partners: A Couple's Perspective*, in SEXUALITY AND PHYSICAL DISABILITY: PERSONAL PERSPECTIVES (Bullard *et al.* eds. 1981).

[53] The application of heightened scrutiny to protect individual privacy will not interfere with the operation of legitimate public health laws, which, unlike the law at issue, are narrowly drawn to meet specific problems of compelling importance. *See, e.g., Jacobson v. Massachusetts*, 197 U.S. 11 (1905).

A. The Statute Is Not a Public Health Measure and Is Counterproductive to Public Health Goals.

1. *The statute does not significantly contribute to combating the spread of acquired immunodeficiency syndrome (AIDS) or to any other public health goal.*

The State cannot seriously contend that the statute is justified generally as advancing the public health or specifically as combating acquired immunodeficiency syndrome ("AIDS") or any other sexually transmitted disease. The statute was enacted in 1816, long before AIDS was known.[54] Its purpose, as the State concedes, was to perpetuate in Georgia the English common law's harsh moral condemnation of the specified sexual conduct, including male homosexuality. Any claim that the statute is justified as protecting the public or individual health is a transparent and unfounded *post-hoc* attempt to capitalize on the current climate of fear about AIDS.

The statute's lack of public health rationale can be seen first by the very loose relationship between its prohibitions and the health problems that Georgia and *amicus* Robinson assert it addresses. The viral agent associated with AIDS appears to be transmitted through exchange of semen or blood, as can occur during anal intercourse and fellatio.[55] But the statute prohibits *all* oral-genital

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[54] Medical description in the United States of what has come to be known as AIDS dates from 1981. *Pneumocystic Pneumonia—Los Angeles*, 30 MORBIDITY & MORTALITY WEEKLY REP. 250 (June 5, 1981), *reprinted in* Public Health Service, Department of Health and Human Services, *Reports on AIDS Published in the Morbidity and Mortality Weekly Report June 1981 through September 1985* 1 (1985) [hereafter MMWR REPORTS].

[55] *Recommendations for Preventing Transmission of Infection With Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace*, 34 MORBIDITY & MORTALITY WEEKLY REP. 681, 682 (Nov. 15, 1985); Krim, *AIDS: The Challenge to Medicine and Science*, in AIDS: THE EMERGING ETHICAL DILEMMAS: A HASTING CENTER REPORT SPECIAL SUPPLEMENT 2, 4 (1985). Ongoing research has identified a virus (HTLV-III/LAV) that is "believed to be a necessary factor in both the etiology and

sexuality, and there is no evidence that AIDS is communicated through heterosexual or lesbian cunnilingus. Moreover, those heterosexuals who have been exposed to AIDS can transmit the virus through vaginal intercourse as well as through some types of conduct forbidden by Georgia.[56] Thus, even to the extent heterosexuals are at risk, deterring the prohibited conduct has minimal impact on heterosexual transmission of AIDS.

As applied to homosexual behavior, the Georgia statute is also overly broad. Lesbians as a group are not at risk for AIDS. Among gay men, oral and anal sex are not inevitably associated with transmission of the virus, even when one gay male partner has been exposed. Use of a condom during oral or anal intercourse greatly reduces the risk of transmission of the AIDS virus.[57]

Most important, given what we know about the fundamental nature and strength of the sex drive in humans, it is unrealistic to think that fear of criminal sanction will effectively deter forbidden sexual conduct in private between consenting adults. If the risk of contracting AIDS, a fatal and thus far incurable disease, to say nothing of the threat of social ostracism, humiliation, and loss of job and friends, does not deter variant sexual conduct, then surely the very slim possibility of arrest and

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pathogenesis of AIDS. [C]ertain factors in addition to infection with [HTLV-III/LAV] could play a role in the development of AIDS." *Id.*

[56] *See, e.g., Heterosexual Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus*, 34 MORBIDITY & MORTALITY WEEKLY REP. 561 (Sept. 20, 1985), *reprinted in* MMWR REPORTS at 112 [hereafter *Heterosexual Transmission*].

[57] *See Heterosexual Transmission, supra* note 56, in MMWR REPORTS at 113; *Questions and Answers*, 252 J. AM. MED. A. 826 (1984). Condoms appears to be effective, so long as they do not rupture. The as-yet unpublished results of research conducted at the University of California indicate that the AIDS virus cannot penetrate the fine membranes of condoms. *Condoms Found Effective*, New York Times Nat'l Ed., Dec. 19, 1985, at 13.

prosecution for private conduct does not do so.[58] The experience of the many jurisdictions in which consensual sexual conduct is not criminal seems to be that the prevalence of homosexuality is about the same as in jurisdictions in which it is illegal.[59] Thus, consensual sodomy laws deter at most a negligible amount of overt homosexual behavior.[60] As a result, even with respect to that subset of sexual conduct prohibited by the statute that does pose a risk of spreading AIDS, the statute has no beneficial public health effect.

2. The statute disserves the public health.

The statute does not deter conduct that spreads AIDS, but it may deter conduct essential to combating it. The achievement of the public health goals of health maintenance, disease prevention, and disease detection and treatment depends upon the cooperation of many individuals, including patients, physicians, hospital personnel, researchers, and government officials. To make sound decisions about individual treatment and public health, both individual physicians and public health personnel must be able to obtain accurate information. Criminal statutes such as Georgia's can seriously undermine these essential public health strategies by causing individuals to conceal or distort relevant information and by inhibiting effective public education efforts. In the case of sexually transmitted diseases such as AIDS, substantial harm to individuals and the public may result. Indeed, researchers have discovered that societies with harsh penalties for homosexual conduct suffer from poorer reporting and treatment of sexually transmitted diseases among homosexuals than more lenient societies.[61]

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[58] *See State v. Saunders*, 75 N.J. 200, 381 A.2d 333, 341-42 (1977) (criminal penalties add no deterrent force to fear of contracting serious illness).

[59] *See* WEINBERG & WILLIAMS, *supra* note 33.

[60] *See* Kimmel, *Psychotherapy and the Older Gay Man*, 14 PSYCHOTHERAPY: THEORY, RESEARCH & PRACTICE 386 (1977).

[61] Ostrow & Altman, *Sexually Transmitted Diseases and Homosexuality*, 10 SEXUALLY TRANSMITTED DISEASES 208, 212 (1983).

a. *The statute may adversely affect the health and treatment of individuals.*

Fearing both social disapproval and legal penalties, many homosexual men and women do not tell their personal physicians about their sexual orientation.[62] A patient runs the risk that members of a physician's or hospital's staff may make accidental or unauthorized disclosure of his or her sexual orientation. Such disclosure presents a risk of prosecution, as well as of intensified discrimination.[63] This concealment may adversely affect the medical care an individual receives,[64] with potentially serious consequences for the individual whose illness is misdiagnosed for some period of time. Fear of punitive government actions also can lead to failure to seek treatment at all. Thus, some people who have been exposed to AIDS may avoid reporting their own exposure fearing that their report may lead to criminal prosecution.[65]

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[62] *See, e.g.*, Dardick & Grady, *Openness Between Gay Persons and Health Professionals*, 93 ANNALS OF INTERNAL MED. 115 (Pt. 1 1980).

[63] *See State v. Saunders*, 381 A.2d at 342 (a criminal statute "operates as a deterrent to . . . voluntary participation" in treatment programs).

[64] For example, physicians may not include in their list of possible diagnoses certain conditions that appear in homosexual men. *See* William, *The Sexual Transmission of Parasitic Infections in Gay Men*, 5 J. HOMOSEXUALITY 291 (1980).

[65] A clear analogy is provided by the effects of the U.S. Army's venereal disease policy during World War I. American soldiers in Europe were subject to court martial if they were diagnosed as having contracted a venereal disease. A. BRANDT, NO MAGIC BULLET 102 (1985). Many military physicians believed that the threat of court martial induced soldiers to conceal their illness for as long as possible. *Id.* at 102, n. 20, 103-05. But the threat of court martial certainly did not prevent the contraction of venereal diseases: more than 380,000 soldiers were diagnosed as having a venereal disease during the period from April 1917 to December 1919. *Id.* at 115.

b. *The statute may adversely affect scientific investigation directed toward containing disease and finding a cure.*

The process of understanding and controlling newly identified diseases such as AIDS urgently requires prompt gathering of accurate information. Diagnosis of individual cases, identification of relevant attributes of the population, finding individuals who may be unknowing or unreported sources of infection, and testing of hypotheses about the origin and spread of a disease, all depend on careful collection of data.[66] A statutory scheme that creates a realistic fear of punishment if certain behavior is disclosed runs the risk of obscuring important data, as individuals simply refuse to volunteer for studies or provide needed information, and of creating false data, as individuals try to conform what they reveal to what they believe is legal. Thus, people who, due to incomplete disclosure, are wrongly diagnosed may continue to be sources of infection without knowing it. Others, who fail to report early symptoms or their own exposure to the disease, also may spread it. Moreover, the public health technique of treating people with whom the patient has had sexual contact requires "the patient's cooperation . . . by assuring that each [contact] is promptly referred, evaluated and given any indicated therapeutic or preventive treatment."[67] The prospect of criminal penalties against themselves and their partner may well deter individuals from making such referrals. A punitive scheme like Georgia's may also inhibit health care professionals from fulfilling the important public health role of passing on relevant information about the incidence of a disease to researchers and public health officials. Historically, such forces have interfered substantially with efforts to control other forms of venereal disease.[68]

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[66] *See* J. MAUSNER AND S. KRAMER, MAUSNER & BAHN'S EPIDEMIOLGY—AN INTRODUCTORY TEXT 287-89 (2d ed. 1985).

[67] *1985 STD Treatment Guidelines*, 34 MORBIDITY & MORTALITY WEEKLY REP. 1085 (Oct. 18, 1985).

[68] Early in the century, for example, many private physicians believed that they would be violating their duty to their patients if

The short history of AIDS shows that fear of punishment has already hindered the current investigation. With respect to at least two important issues—the existence of potentially high risk to recent immigrants from Haiti,[69] and the transmissibility of the AIDS virus from women to men [70]—there is reason to believe that falsifications of information, caused by fear of punishment, have distorted the epidemiological picture. Finding these and other crucial pieces of the AIDS puzzle should not have to depend on the ability of epidemiologists to guess whether patients are not telling the truth because they fear being punished.

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they reported syphilis cases. A. BRANDT, *supra* note 65, at 43, 183-84. Non-reporting by physicians has persisted, frustrating public health efforts to control syphilis and gonorrhea. *Id.* at 46.

[69] Initial attempts to analyze the incidence of AIDS identified Haitians who had recently arrived in the United States as a high risk group "having neither a history of homosexuality nor a history of drug abuse." *Update on Acquired Immune Deficiency Syndrome (AIDS)—United States*, 31 MORBIDITY & MORTALITY WEEKLY REP. 507, 511 (Sept. 24, 1982), *reprinted in* MMWR REPORTS at 12. The current view of the Centers for Disease Control, however, is that Haitians are *not* members of a discrete risk group. *Update: Acquired Immunodeficiency Syndrome—United States*, 34 MORBIDITY & MORTALITY WEEKLY REP. 245 (May 10, 1985), *reprinted in* MMWR REPORTS at 907. One explanation for epidemiologists' failure to identify an overlap between the Haitians and other identified high-risk groups, such as homosexual men and intravenous drug users, is that many Haitian patients were afraid to tell investigators the truth. Admitting to illegal behavior in one's new country—and thereby risking deportation—may have seemed too great a risk to take simply to provide information to doctors.

[70] A study of military personnel done at Walter Reed Army Medical Center shows a much higher incidence of female-to-male transmission of HTLV-III/LAV virus than most other United States reports. *Compare* Redfield, Markham, Salahuddin, Wright, Sarngadharan & Gallo, *Heterosexually Acquired HTLV-III/LAV Disease (AIDS Related Complex and AIDS)*, 254 J. AM. MED. A. 2094 (1985) *with Heterosexual Transmission*, *supra* note 56. The question of the incidence of female-to-male transmission is an important area of current inquiry. It is possible that the other reports show an artificially low incidence of such transmission. But another explanation for the disparity is that the military personnel in the

c. *The statute interferes with health education efforts designed to encourage safer sexual practices.*

The statute also may harm the public health by interfering with efforts intended to advise the public how to minimize or avoid contracting the disease. Public health officials and private groups have been actively encouraging people to change to "safe sex" behavior.[71] "[T]he best chance of controlling the AIDS epidemic at present is through education and counseling to enhance behavioral change and personal responsibility."[72] Researchers report dramatic changes in sexual behavior to reduce the risk of AIDS in areas where major educational efforts are underway, demonstrating the urgent importance of such efforts.[73]

Such community effort and support are made more difficult in an environment in which a concomitant of participating in educational efforts is self-incrimination. Attending an educational presentation on "safe sex," for example, could be seen as an admission of engaging in

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Walter Reed study were reluctant to admit to homosexual activity or intravenous drug use, either of which could lead to discharge. *See, e.g., Rich v. Secretary of the Army*, 735 F.2d 1220 (10th Cir. 1984) (Army discharge of homosexual man).

[71] As noted, the use of condoms during oral and anal sex is a preventive measure. Gay men can also engage in other, low risk types of sexual conduct, including, for example, kissing, hugging, body rubbing, and mutual masturbation. *See* McWHIRTER & MATTISON, *supra* note 14, at 276-77.

[72] Dr. James O. Mason, Acting Assistant Secretary for Health, Department of Health and Human Services, Testimony before the Republican Study Committee, House of Representatives (Nov. 7, 1985).

[73] *See, e.g., Self-Reported Behavioral Change Among Gay and Bisexual Men—San Francisco*, 34 MORBIDITY & MORTALITY WEEKLY REP. 613 (Oct. 11, 1985); McKusick, Wiley, Coates, Stall, Saika, Morin, Charles, Horstman & Conant, *Reported Changes in the Sexual Behavior of Men at Risk for AIDS, San Francisco, 1982-84—the AIDS Behavioral Research Project*, 100 PUB. HEALTH REP. 622 (1985); *Declining Rates of Rectal and Pharyngeal Gonorrhea Among Males—New York City*, 33 MORBIDITY & MORTALITY WEEKLY REP. 295 (June 1, 1984), *reprinted in* MMWR REPORTS at 59.

sexual practices prohibited by the statute. Criminalization is likely to compromise the efficacy of informal educational networks by making people more cautious about what they reveal about themselves to acquaintances. It also presents state public health officials with the awkward choice of appearing to suppress information about safe sex techniques or appearing to condone felonious conduct.

In short, the statute is likely to deter *only* conduct necessary to *improve* the public health. From a public health standpoint, the statute is simply counterproductive.

B. The Georgia Statute Does Not Further Any Mental Health Objectives and Injures the Mental Health of Many Members of Society, with Harmful Repercussions for Individual Physical Health.

The statute is also counterproductive with respect to mental health goals. Because freedom to choose whether to engage in the prohibited conduct *benefits*, rather than harms, individual mental health, deterring individuals from engaging in the types of sexual conduct specified—even if criminal laws could do so—cannot be defended as a mental health objective. Similarly, because homosexuality is not pathological, individual mental health is not served by official attempts to "deter" people from becoming homosexuals.

Even assuming, *arguendo*, that lowering the incidence of homosexual orientation in society were in some other way a legitimate governmental objective, criminalization of homosexual conduct does not have this effect. Although it is clear that same-sex orientation and activity do not indicate mental disorder and illness, it is less clear why some people have a same-sex orientation. Few of the theories advanced to explain the formation of sexual orientation are supported by reliable data.[74] Certainly, homosexual orientation is not a matter of simple choice.

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[74] Several popular theories have been disproved. *See* A. BELL, M. WEINBERG & S. HAMMERSMITH, SEXUAL PREFERENCE: ITS DEVELOPMENT IN MEN AND WOMEN (1981) [hereafter A. BELL, *et al.*].

It is a set of emotions and proclivities often established early in life. Research indicates that sexual orientation develops independently of isolated sexual experiences, and the data do not support the idea that early childhood homosexual activity has any direct relationship to later sexual orientation.[75] Indeed, there are no empirical data to support the popular myth that homosexual orientation or behavior results from "contagion" by other homosexuals. The only consistent findings are that homosexuals have many more and much stronger sexual fantasies about members of their own sex, and that these fantasies usually appear during childhood and early adolescence.[76]

Once established, homosexual orientation is not easily modified. Researchers agree that the sexual orientation of only a small fraction of homosexual people who are highly motivated to change has been or can be modified through therapy.[77] Consensual sodomy laws thus have little or no effect on the incidence of homosexual orientation.[78]

Furthermore, statutes outlawing variant sexual behavior do cause substantial psychological harm, which, in turn, may have serious consequences for physical health.

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[75] *E.g.*, A. BELL, *et al.*, *supra* n. 74, at 97-113 (62% of heterosexual men reported that their first sexual encounter was with another male; 39% of homosexual men reported such experience); *see* Stephen, *Parental Relationships and Early Social Experiences of Activist Male Homosexuals and Male Heterosexuals*, 82 J. ABNORMAL PSYCHOLOGY 506 (1973).

[76] Storms, *Theories of Sexual Orientation*, 38 J. PERSONALITY & SOC. PSYCHOLOGY 783 (1980).

[77] *See* Coleman, *Changing Approaches to the Treatment of Homosexuality: A Review*, in HOMOSEXUALITY, *supra* note 12, at 81-88 (1982); Marmor, *Clinical Aspects of Homosexuality*, in HOMOSEXUAL BEHAVIOR: A MODERN REAPPRAISAL 277 (Marmor ed. 1980). Moreover, for many homosexuals, seeking to change sexual orientation would be an inappropriate goal of psychotherapy. *See* Davison, *Politics, Ethics and Therapy for Homosexuality*, in HOMOSEXUALITY, *supra* n. 12, at 89-98 (1982).

[78] Kimmel, *supra* note 60.

in part because their behavior is punishable by criminal law,[79] homosexuals become stigmatized as "deviants"[80] and are viewed in terms of undesirable stereotypes. This process results in prejudice—called homophobia—against homosexuals by many heterosexual people. Homosexuals develop coping mechanisms, which are common traits in most persecuted groups. These traits can include excessive concern with minority group membership, feelings of insecurity, withdrawal, militancy, and neuroticism. They can also include denial of membership in the group, self-derision, self-hatred, hatred of others in the group, and acting out self-fulfilling prophesies about one's own inferiority.[81] The great majority of gay people come to terms with their sexual orientation and integrate it into their lives. Studies demonstrate that these homosexuals are the most psychologically well-adjusted. But the small group of homosexuals who do not overcome this are more troubled and dysfunctional, and may act in self-destructive ways and destructively toward other gay people.[82] This clinically observed psychological condition is known

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[79] Although sodomy statutes apply to heterosexual conduct as well as homosexual conduct, in practice they are enforced almost exclusively against homosexuals. *See, e.g.*, Gallo, *The Consenting Adult Homosexual and the Law: An Empirical Study of Enforcement and Administration In Los Angeles County*, 13 U.C.L.A. L. REV. 643 (1966); WEINBERG & WILLIAMS, *supra* note 33. It is well-known in both law, *see Brown v. Board of Educ.*, 347 U.S. 483, 494-95 (1954), and psychology, *see, e.g.*, J. JONES, PREJUDICE AND RACISM 138-40 (1972), that social or moral pronouncements as expressed through the law and imposed by a majority on a minority can through the process of stigmatization significantly injure the mental health of members of the minority.

[80] The term "deviant" as used in the social sciences refers to the social *reaction* to behavior, not to the intrinsic characteristics of the behavior itself. H. BECKER, OUTSIDERS: STUDIES IN THE SOCIOLOGY OF DEVIANCE (1963).

[81] *See, e.g.*, G. ALLPORT, THE NATURE OF PREJUDICE (1954).

[82] Homosexuals who have been able to express their homosexuality are psychologically healthier than those who have repressed it. BELL & WEINBERG, *supra* note 34; Hammersmith & Weinberg, *Homosexual Identity: Commitment, Adjustment, and Significant*

as "internalized homophobia." [83] This psychological harm is a significant health cost of the Georgia statute.

By contributing to imposing internalized homophobia, criminal sodomy statutes also harm the effort to combat AIDS. Despite major shifts in the at-risk population to "safe sex" practices, a small minority of gay men continues to engage in dangerous conduct. To a significant extent, internalized homophobia may cause this destructive and self-destructive behavior. Although this group is very small as a percentage of all gay men, *see* pp. 9-10, *supra*, for a disease with the etiology of AIDS the consequences are tragic.

In terms of both physical and mental health, the statute is counterproductive.

CONCLUSION

For the foregoing reasons, *amici* respectfully urge this Court to affirm the decision of the United States Court of Appeals for the Eleventh Circuit.

Respectfully submitted,

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Others, 36 SOCIOMETRY 56 (1973); WEINBERG & WILLIAMS, *supra* note 33.

[83] *See* Gonsiorek, *Psychotherapeutic Issues with Gay and Lesbian Clients*, in 3 INNOVATIONS IN CLINICAL PRACTICE: A SOURCEBOOK 73-76 (Keller *et. al.* eds. 1984); Malyon, *Psychotherapeutic Implications of Internalized Homophobia in Gay Men*, in HOMOSEXUALITY AND PSYCHOTHERAPY: A PRACTITIONER'S HANDBOOK OF AFFIRMATIVE MODELS 59-69 (Gonsiorek ed. 1982).